March 2011

Montana Central Tumor Registry Newsletter

MONTANA CANCER CONTROL PROGRAMS
MONTANA DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES

The CSEP Program has a New Manager

Laura Biazzo will begin as Program Manager for the Cancer Surveillance and Epidemiology Program on April 11, 2011.

Laura began working for the Montana Department of Public Health and Human Service in 2008 as the Epidemiologist and Program Evaluator for the Montana Tobacco Use Prevention Program. Her primary responsibility was to coordinate, analyze and disseminate Montana's tobacco related surveillance and evaluation data and results. Before moving to Montana, Laura was a researcher with the Centers for Disease Control and Prevention's Division of Nutrition, Physical Activity, and Obesity. There, her research focused on public health and urban planning issues through Health Impact Assessment (HIA) projects across the country. Specifically, Laura provided HIA technical assistance to health departments and other organizations to prospectively evaluate the impact urban planning projects may have on public health. Laura holds a Master of Public Health degree in Epidemiology from Emory University in Atlanta, GA.

Originally from Duluth, Minnesota, Laura has become settled in Montana because it is just like home—but with mountains! She spends her free time running, mountain biking, and skiing. Laura is very excited to start working with the cancer prevention community in Montana!

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Meet the Registrar

Dani Patritti, RN
St. James Hospital

My name is Dani Patritti. I am an RN at the St James Radiation Department in Butte, MT. I am also part time/temporary tumor registrar. I have been abstracting since August 2009. I am 36 years old, married and have 2 children. I enjoy camping, fishing, baking, gardening, and jogging. My family is my life. Everything I do is because of them.

I am very blessed to be a part of the registry. It is a great learning experience. Each day is a gift. I continue to learn and enjoy every aspect of my profession.

Grade Path System and Grade Path Value

Grade Path System indicates whether a 2, 3, or 4 grade system was used in the path report to describe the grade. If the grade is described as a fraction (x/y) the Grade Path System is the denominator.

Grade Path System: code the number of grades used in the grading system reported in the path report.

Grade Path Value documents the numerator or first number of a tumor grade reported in a 2, 3, or 4 grade system. The code in this field cannot be greater than the corresponding code in Grade Path System.

Grade Path Value: Code the value of the numeric grade from the path report if Grade Path System was assigned code 2-4. Leave blank if the numeric grade is given but grading system is not stated.

Example: Mucinous carcinoma, grade 1/3
Grade Path Value = 1
Grade Path System = 3

Example: Adenocarcinoma, grade 2
Grade Path Value = Blank
Grade Path System = Blank

Code the Grade Path system and the Grade Path Value from the same tissue used to code the data item, Grade. Grade Path Value is paired with Grade Path System to describe the original grade of the tumor. These data elements supplement but do not replace the data item, Grade. Note Histologic grade is another name for overall grade or grade NOS and takes priority over a nuclear or architectural grade.

Leave blank if no pathologic grade is available.

Leave blank if only verbal description of grade is reported, such as well differentiated, moderately differentiated, poorly differentiated, low/high grade, or anaplastic etc.

Leave blank if another grading system is used in the path report, such as Bloom-Richardson, Fuhrman, Gleason, WHO grade. The site-specific grading systems are captured in the collaborative stage site specific fields.

Leave blank for Lymphomas and Hematopoietic malignancies.

Grade Path value and Grade Path System should both be coded or both be blank. The Value of the Grade data item cannot be 9 if both Grade Path Value and Grade Path System are coded.

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Grade Continued

Case Scenario 1: Final path diagnosis from endometrial biopsy is adenocarcinoma, grade 2 of 3. Final path diagnosis from hysterectomy is adenocarcinoma of endometrium grade 1 of 3.

Grade = 3
Grade Path Value = 2
Grade Path System = 3

Case Scenario 2: Final path diagnosis was invasive adenocarcinoma of the stomach, moderately differentiated.

Grade = 2
Grade Path System = blank
Grade Path Value = blank

Case Scenario 3: Final path diagnosis is infiltrating ductal carcinoma of the right breast, Bloom Richardson sore 4.

Grade= 1
Grade Path System = blank
Grade Path Value = blank

Case Scenario 4: The path department in this facility has a written policy that a 3 grade system is used on all cases that are not otherwise documented on the path report. Final path diagnosis was adenocarcinoma of the right fallopian tube grade 2.

Grade = 2
Grade Path Value = blank
Grade Path system = blank

Case Scenario 5: Final path diagnosis is adenocarcinoma of the ascending colon, grade 1. On the AJCC staging form the surgeon documents grade 1/3.

Grade = 1
Grade Path Value = blank
Grade Path System = blank

Case Scenario 6: Final path diagnosis was moderately differentiated adenocarcinoma of the endometrium, grade 2/3.

Grade = 2
Grade Path Value = 2
Grade Path System = 3

Case Scenario 7: Gleason score 3+3 = 6

Grade = 2
Grade Path Value = blank
Grade Path System = blank

Source: NAACCR 2010-2011 Webinar Series

Certificate of Excellence Recipients

The following hospitals and Dermatology offices received a certificate for the 2010 Fourth Quarter, acknowledging their timeliness in reporting. Ninety percent of their cases were reported within 12 months.

Facility	City
Dr. Philip Tallman	Billings
Advanced Dermatology of Butte	Butte
Dermatology Associates	Kalispell
Dermatology Associates	Great Falls
Associated Dermatology	Helena
Broadwater Health Center	Townsend
Rosebud Health Care Center	Forsyth
Frances Mahon Deaconess	Glasgow
Big Horn County Memorial	Hardin
Central Montana Medical Center	Lewistown
St. Patrick Hospital	Missoula
St. Joseph Medical Center	Polson
Clark Fork Valley Hospital	Plains
Great Falls Clinic	Great Falls
Yellowstone Pathology Institute	Billings

Q & A — Bladder Tumors

SEER Inquiry System

Question 20071016

The new multiple primary rule M7 states that tumors diagnosed more than three years apart are multiple primaries. Does this apply to in situ bladder tumors that occur more than three years apart and to an in situ tumor that occurs three years after an invasive tumor?

Answer: Use the MP/H rules in order. Rule M6 comes before rule M7. M6 states that bladder tumors with certain histologies are a single primary. It is a single primary regardless of timing if there is any combination of: papillary carcinoma (8050), transitional cell carcinoma (8120-8124), and papillary transitional cell carcinoma (8130-8131). Rule M7 applies to bladder tumors with histologies other than those listed above. If you have such a case, rule M7 applies to in situ tumors and to an in situ three years after an invasive.

Question 20110007

How many primaries are represented and how should histology be coded when a bladder resection shows a tumor with invasive small cell neuroendocrine carcinoma (8041/3) with high-grade papillary urothelial carcinoma in situ (8130/2), adenocarcinoma in situ (8140/2) along with multifocal flat urothelial carcinoma in situ?

Answer: Ignore the in situ histologies. This is a single primary. Code invasive small cell neuroendocrine carcinoma (8041/3).

Question 20100009

A patient has a history of invasive bladder cancer diagnosed several years ago in another state. Now in 2009, he is admitted to your hospital with a positive biopsy for transitional cell carcinoma of the bladder. Is this a new primary (since you do not know the histology of the previous bladder cancer) or can you assume it was urothelial in the past and use rule M6 to consider the 2009 diagnosis as not a new primary?

Answer: Apply rule M6. The 2009 diagnosis is not a new primary. Transitional cell carcinomas account for more than 90% of bladder cancers. If the patient actually had a small cell, squamous cell, or adenocarcinoma in the past, it would be highly unlikely that no mention was made in the medical record that the patient had one of these rare bladder tumors.